MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, September 13, 2002
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: PUBLIC COMMENT

MR. HACKBARTH: We are now at our public comment period of about 15-minutes. Let me issue my standard request, Fred, that people please keep their comments succinct. If somebody before you in line makes the same comment, don't necessarily feel obliged to repeat it.

MR. GRAEFE: Thank you, Mr. Chairman. Fred Graefe of Hunton & Williams representing the Proton Therapy Payment Consortium which consists of seven world class hospitals, M.D. Anderson, University of Florida, University of Pennsylvania, New York Presbyterian, Mass General, Indiana University, and Loma Linda. We're here to raise a concern about the outpatient PPS rule. That, I guess for a moment it reminds me of 1983 when Senator Durenberger and Sheila and her boss were the leading forces for the establishment of the inpatient PPS system.

CMS' proposed rule collapses four payment codes for proton therapy into one single lowest paid code. We're requesting that CMS reinstitute a complex payment code for that. I have from M.D. Anderson here with me Mr. Mitchell Tinkick who is the expert who set it up at Loma Linda and now at M.D. Anderson. We would urge consideration by you to include in this draft letter you were referencing earlier in the discussion, a reference to this. We have given your staff a long position paper about it, as well as some draft suggested language.

Thank you again for your consideration.

MR. TINKICK: I will keep my comments very brief. Thank you for the opportunity. I had the pleasure of being involved in proton therapy when I first joined Loma Linda University Medical Center in 1990 and am now involved and speak today on behalf of the consortia, but I'm involved with the M.D. Anderson proton therapy efforts.

The new rules, as Fred suggested, collapse four distinct proton therapy treatment deliveries paid under two APC codes into a single code which simple does not recognize issues of acuity, resource differentiation associated with complex therapies. We feel also, based on our review, that the rule of the payment rate, the single rate may be based on the data of a single provider or principally from a single provider.

This issue requires broader input from the proton community, which I represent today. We are going to be visiting with Mr. Scully in the next two weeks to discuss this issue. It's one that's of importance to our representatives on the Hill. As Fred suggested, to whatever extent you can, we would appreciate this issue being addressed in your letter.

Thank you.

MR. CONNELLY: My name is Jerry Connelly, representing the American Academy of Family Physicians. I just wanted to make a couple of brief comments relative to your last issue on the agenda that you dealt with relative to physician-administered drugs in the Part B program.

The academy commends MedPAC for examining this issue. As it was pointed out, this is something that is growing at 20 percent

per year. Because of that it's an important issue for you to deal with. We'd like you to understand and recognize, which I think you do, that there is an attempt built in in a policy to suppress the growth, or at least the payment for these kinds of things, these drugs. It is done by including this particular expenditure in the formula for determining the conversion factor for the Medicare physician fee schedule that is called the sustainable growth rate.

However, these drugs, as was pointed out, are not paid for under the fee schedule, yet they are used to calculate the conversion factor that is applied to determine what the fee schedule will be for procedures. These procedures are delivered by physicians, and by non-physicians, I would point out, who in some cases do not have a license to administer drugs and therefore don't administer drugs in their office. Widely, physicians of a lot of specialties do not administer drugs procedurally in their office. So this is something that is used to calculate the formula for a conversion factor for procedures, yet those drugs are not paid for under that sustainable growth rate.

This is, therefore, something that we would -- we know that MedPAC has dealt with before. You've talked about the SGR, you've made a recommendation relative to the SGR and modifications or revisions to the SGR that should be made. That has not been taken up yet, but we believe that this particular anomaly is another compelling reasons that the SGR needs to be revised, not only in the short term but in the long term. We urge you to continue to take that under consideration as you deal with this issue as well.

MS. SCHRADER: Hi, I'm Ashley Schrader representing the American Hospital Association. First of all, we really want to applaud the commissioners for their discussions on technology; very difficult topic, especially the incorporation of new technology payments into a fixed payment system. We know that this is a challenge and a struggle and we look forward to both discussions in October and your March upcoming report.

However, I'm up here to make a comment about the outpatient prospective payment system discussion. The AHA agrees with MedPAC staff and the commissioners in assessing that it's incredibly new, it's incredibly complex, and potentially there have been wild, dramatic swings in payment rates, both from '01 to '02 and again from '02 to '03. Congress when they developed the system put in place these transitional corridor payments and the hold harmless payments that are due to expire at the end of December of next year. We're concerned that in light of this system that's still undergoing significant changes that we would urge the commissioners to consider a recommendation that would keep those corridor payments in place for a little longer.

Thank you.

MS. SMITH: Good afternoon. My name is Kathleen Smith. I'm a nephrology nurse and I'm here representing Frizentius Medical Care. We're the largest provider of dialysis services in the country serving about 26 percent of the dialysis population. I wanted to comment on the last topic, the Part B drug coverage in

Medicare. We also applaud the Commission for looking at this most important area; a significant area where Medicare reform is needed.

I wanted to comment that the dialysis composite rate was a very early prospective payment in the Medicare system implemented in 1983 along with DRGs, actually I think just ahead of DRGs. However, over the years as these new drugs came on the market they've been treated as pass-through payments essentially, and the composite rate is no longer a prospective payment. MedPAC continues to report about 35 percent of what's paid to dialysis providers is paid outside of that composite rate.

Frizentius would very much like to see Medicare reform that reestablishes prospective payment for dialysis. That would involve, obviously, including the drugs administered today in the composite rate payment. We believe that it's linked obviously to the AWP discussions, although we brought this up prior to the AWP issue being discussed at this level.

So we would hope that the Commission would recognize that, as MedPAC has in the past, the composite rate does not cover the cost of a dialysis treatment. We have shared with MedPAC staff four years of our history of our actual drug costs for the drugs administered in dialysis settings. Certainly as the largest provider, the discounts we receive would be higher than any of the other providers. MedPAC staff does have that at their disposal. It shows the extent to which we've become dependent on the revenue from the drugs to offset the underfunding of the composite rate.

So we would like to see MedPAC, for the drugs administered in the outpatient dialysis setting, to support ESRD payment reform that would include those drugs in the payment and reestablish prospective payment in dialysis.

I thank you very much.

MR. THOMAS: Good morning. My name is Peter Thomas. I'm here on behalf of the Consortium for Citizens with Disabilities Health Task Force. I am speaking on behalf of consumers, consumer organizations, but also disability related organizations that may have a provider focus as well who are part of the coalition. I happen to have two artificial limbs. I've used a wheelchair and I've used braces. So today I'd like to speak about competitive bidding and apologize that I wasn't here yesterday to offer my comments during that discussion.

I have heard what was discussed yesterday and I'm told that there was some degree of skepticism on some portions of that competitive bidding discussion. I'm glad to hear that because I can tell you that the consumer groups and the disability related organizations that I work with, and I've got a letter to this effect where 25 groups have signed on, strongly oppose competitive bidding of durable medical equipment, some orthotics and supplies, primarily based on the fact that we're very concerned about access issues, primarily concerned about the quality of care which may arise under a competitive bidding scenario, and also concerned about the choice of provider and the lack of choice of provider that will inevitably occur when certain providers are given contracts and certain providers are

not.

Presumably the low bidding providers receiving the contracts, and of course what that might do for quality is a very strong concern of ours.

Right now there's a Medicare fee schedule where people or providers essentially compete with each other. They just don't compete based on price. They compete based on how well they serve the physician who refers them, how well the patient is satisfied with the service that they have provided, how quickly they get back in touch with the person whose wheelchair or other kind of durable medical equipment needs servicing, how quickly they pick up the phone and respond.

When you go to a competitive bidding scenario, all that becomes secondary and the sole focus becomes the price alone. There are ways that Medicare can adjust prices. We're very concerned that competitive bidding is not the way to do it.

When you have competitive bidding, right now that would represent a fundamental change in how the Medicare fee-for-service program is run. Essentially what you'd be doing is turning the fee-for-service program into a PPO where you'd get certain providers who would agree to decrease their prices in exchange for additional referrals. That's just a fundamental change from where the fee-for-service program under Medicare current stands. In every Medicare debate on Capitol Hill that I've ever heard, people go out of their way just to mention how the fee-for-service program won't be touched and will always be available to people who want to stay in it. This represents a major departure from that.

Durable medical equipment and orthotics and supplies are not just widgets. There's a lot of service connected to them. There's a lot of customization, even involved in things that you might not think. Oxygen therapy, there's a huge service component in oxygen therapy that literally could mean the difference between life and death of the patient. Customized wheelchairs, how a person sits in a mobility device is a major professional service that's provided. Orthotics shouldn't even be included in durable medical equipment. It's really more of a professional service that results in a device at the very end.

But the fact is that when you start competitively bidding those kinds of devices and services, you're really getting into competitively bidding professional care. And if you're going to reach that conclusion, that you're ready to competitively bid professionally bid care under Medicare, than why stop at this benefit category? Why experiment with this area that disproportionately people with disabilities and chronic illnesses rely on to be functional and independent? Why not extend it to hospitals? Why not extend it to physician fees and therapy services?

Obviously, the political winds would be very strongly opposed to that, and that's exactly why I'm mentioning it. Why is it that it's okay to do it in this area but it's not okay to do it in those other areas?

I'll just say that the most important quality assurance mechanism is the ability in the fee-for-service program to choose

a different provider if the provider that you're currently going to isn't serving your needs. To restrict that in any way would be a real shame.

I'll distribute this letter for those who are interested in looking at it. Thank you.

MR. HACKBARTH: Thank you everybody.